

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN4167AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2009
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOME LLC ELKO 2		STREET ADDRESS, CITY, STATE, ZIP CODE 1680 WINCHESTER DRIVE ELKO, NV 89801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Surveyor: 28380 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 8/18/2009. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was ten. Ten resident files were reviewed and seven employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A. The following deficiencies were identified:	Y 000		
Y 434 SS=D	449.229(3) Emergency Drills NAC 449.229 3. A drill for evacuation must be performed monthly on an irregular schedule, and a written record of each drill must be kept on file at the facility for not less than 12 months after the drill. This Regulation is not met as evidenced by: Surveyor: 28380	Y 434		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN4167AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/18/2009
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOME LLC ELKO 2			STREET ADDRESS, CITY, STATE, ZIP CODE 1680 WINCHESTER DRIVE ELKO, NV 89801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 434	Continued From page 1 Based on record review on 8/18/09, the facility did not ensure that monthly evacuation drills were conducted on an irregular schedule for the past 1 of 12 months (February 2009). Severity: 2 Scope: 1	Y 434			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.